Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TEXAS 77504

Respondent Name
AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-04-6315-01

MFDR Date Received
FEBRUARY 11, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated March 4, 2004: "The Carrier did not provide a proper explanation in conjunction with the 'F' payment exception code as required by the TWCC rules and Commission instructions." "The Carrier is allowed to deduct any personal items and may only deduct non-documented services and items and services, which are not related to the compensable injury. At that time, if the total audited charges for *the entire admission* are below $40,000, the Carrier may reimburse at a 'per diem' rate for the hospital services. However, if the total audited charges for *the entire admission* are at or above $40,000, the Carrier shall reimburse using the 'Stop-Loss Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission'." "In this instance, the audited charges that remained in dispute after the last bill review by the insurance carrier were $222,158.87. The prior amounts paid by the carrier were $35,859.80. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation Reimbursement Amount of **$130,759.35, plus interest**."

Requestor's Supplemental Position Summary Dated October 27, 2011: "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeal's Final Judgment…The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons…The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons…"

Amount in Dispute: $130,759.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated February 27, 2004 : "The Requestor asserts it is entitled to reimbursement in the amount of $166,619.15, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement…Carrier requests an **Order of Reimbursement** for any payment previously made over the amount calculated under the methods described in the above referenced SOAH decisions…"

Respondent's Supplemental Position Summary Dated September 8, 2011: "Respondent submits the Respondent's Post-Appeal Supplemental Response as a response to and incorporation of the Third Court of Appeals Mandate in Cause No. 03-07-00682-CV…Based upon Respondent's initial and all supplemental responses, and in accordance with the Division's obligation to adjudicate the payment, in accordance with the Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the

stop-loss exception. The Division must conclude that payment should be awarded in accordance with the general *per diem* payment in accordance with 28 Texas Administrative Code §134.401 (repealed)…"

Responses Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas 78701

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
July 16, 2003 through July 24, 2003	Inpatient Hospital Services	$130,759.35	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.304, 25 *Texas Register* 2115, applicable to dates of service on or after July 15, 2000, sets out the procedures for medical payments and denials.
2. Former 28 Texas Administrative Code §133.305, 27 *Texas Register* 12282, amended effective January 1, 2003, sets out general provisions for medical dispute resolution.
3. Former 28 Texas Administrative Code §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
4. Former 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
5. Former 28 Texas Administrative Code §134.600, 27 *Texas Register* 12359, effective January 1, 2003, requires preauthorization for inpatient hospitalizations.
6. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
7. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 3, 2003
   - 481-Reimbursement was calculated using the stop loss method.
   - 480-Reimbursement based on the Acute Care Inpatient Hospital Fee Guideline per diem rate allowances.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 375-Please see special *note* below.
   - 270-No allowance has been recommended for this procedure/service/supply please see special *note* below.
   - 240-Preauthorization not obtained.
   - F-Per preauthorization.
   - F-Reduced according to fee guideline.
   - *Note* Payment based on the TWCC per diem allowance for inpatient hospital stay, as documentation does not idicate [sic] any services that are unusually extensive or costly. Payment based on 5 days inpatient con.

   Explanation of benefits dated October 31, 2003
   - 270-No allowance has been recommended for this procedure/service/supply please see special *note* below.
   - *Note* see attached letter of re-evaluation for case # 277230.
   - F-Not according to treatment guidelines.

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Does a preauthorization issue exist in this dispute?
6. Is the respondent entitled to an order of reimbursement or refund?
7. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." On August 10, 2011, both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The Division received supplemental information from the respondent on September 8, 2011, and then received supplemental information from the requestor on October 27, 2011. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the Division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services in this case are unusually extensive; and whether the admission and disputed services in this case are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet those three factors.

1. 28 Texas Administrative Code §133.304(c), 25 *Texas Register* 2128, effective July 15, 2000, states, in pertinent part, that "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section." The requestor asserts in its position statement that: "The Carrier did not provide a proper explanation in conjunction with the 'F' payment exception code as required by the TWCC rules and Commission instructions."

   Review of the submitted documentation finds that the explanation of benefits dated September 3, 2003 and October 31, 2003 were issued using the division-approved form TWCC 62 and noted payment exception codes of "481-Reimbursement was calculated using the stop loss method"; "480-Reimbursement based on the Acute Care Inpatient Hospital Fee Guideline per diem rate allowances"; "217-The value of this procedure is included in the value of another procedure performed on this date"; "240-Preauthorization not obtained"; "F-Per preauthorization"; "F-Reduced according to fee guideline"; "*Note* Payment based on the TWCC per diem allowance for inpatient hospital stay, as documentation does not idicate [sic] any services that are unusually extensive or costly. Payment based on 5 days inpatient con"; and "F-Not according to treatment guidelines'.

These payment exception codes support an explanation for the reduction of reimbursement based on the Per Diem provision in former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The Division therefore concludes that the insurance carrier has met the requirements of §133.304(c).

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier on September 3, 2003 and October 31, 2003 finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $222,158.87. The Division concludes that the total audited charges exceed $40,000.

3. The requestor in its original position statement asserts that "…if the total audited charges for *the entire admission* are at or above $40,000, the Carrier shall reimburse using the 'Stop-Loss Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission'." As noted above, the Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement dated October 27, 2011 the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The requestor's supplemental position statement asserts that:

   > "The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons; first, this type of surgery is unusually extensive when compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine; second, this type of surgery requires additional, trained nursing staff and specialized equipment (such as the operating table) thereby making the hospital services unusually extensive; and third, the median length of stay ("LOS") for workers' compensation inpatient admissions is three days whereas the length of stay for this admission exceeds the median LOS. Finally, any evidence of comorbidities, which should be considered, is part of the medical records, which have been previously filed."

   The requestor's categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor's position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the Division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

4. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly

services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

> "The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons: first the median charge for all workers' compensation inpatient surgeries is $23,187; the median charge for workers' compensation surgeries of this type is $39,000; therefore the audited billed charges for this surgery substantially exceed not only the median charges, but also the $40,000 stop-loss threshold; second, as mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment and specially trained, extra nursing staff were required, thereby adding substantially to the cost of surgery in comparison to other types of surgeries."

The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for both types of surgeries, and therefore fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in "other types of surgeries." As noted above, the Third Court of Appeals' November 13, 2008 opinion stated that "…the Stop-Loss Exception was meant to apply on a case-by-case basis in a relatively few cases." The Division concludes that the requestor failed to demonstrate that the specific services in this dispute were unusually costly when compared to similar spinal surgery services or admissions.

5. According to the explanation of benefits, the respondent denied reimbursement for three of the eight inpatient days based upon reason code "240-Preauthorization not obtained".

   28 Texas Administrative Code §134.600(h)(1), 27 *Texas Register* 12359, effective January 1, 2003, states "The non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions including the principal scheduled procedure(s) and the length of stay."

   The requestor submitted a copy of a preauthorization report dated June 30, 2003 that supports preauthorization for "Fusion L3-4 with refusion L4-S1" and "Lumbar Laminectomy" for "2 surgical".

   The requestor billed for eight inpatient days. A review of the submitted explanation of benefits indicates that the respondent paid for two inpatient days. The Division finds that the requestor has not supported that the six unpaid inpatient days were preauthorized; therefore, the EOB denial of "240" is supported.

6. In its February 27, 2004 response to the request for medical fee dispute resolution, the insurance carrier and respondent in this dispute requested "...an **Order of Reimbursement** for any payment previously made over the amount calculated under the methods described in the above referenced SOAH decisions." Former 28 Texas Administrative Code §133.305(a)(2)(C), 27 *Texas Register* 12282, effective January 1, 2003, provided that "a carrier dispute of a health care provider reduction or denial of the carrier request for refund of payment for health care previously paid by the carrier (refund request dispute)" can be a medical fee dispute. Former 28 Texas Administrative Code §133.307(b)(3), 27 *Texas Register* 12282, effective January 1, 2003, specified that "The carrier... in a dispute involving a carrier's refund request" may be a requestor in a medical fee dispute. Section 133.307(e) required that "…carrier requests for medical dispute resolution shall be made in the form, format, and manner prescribed by the commission." Section 133.307(e)(2)(B) required that the request shall include "a copy of each… response to the refund request relevant to the fee dispute..." Former 28 Texas Administrative Code §133.304(p), 25 *Texas Register* 2115, effective July 15, 2000, provided, in pertinent part, that "An insurance carrier may request medical dispute resolution in accordance with §133.305 if… the insurance carrier has requested a refund under this section, and the health care provider: (1) failed to make payment by the 60th day after the date the insurance carrier sent the request for refund…" The Division

finds that the insurance carrier's position statement in response to the health care provider's request for medical fee dispute resolution does not constitute a request for refund request dispute resolution in the form and manner required by former applicable version of 28 Texas Administrative Code §133.307. Furthermore, no documentation was found to support that the insurance carrier ever presented a refund request to the health care provider for a specific refund amount in accordance with §133.304(p). The Division concludes that the insurance carrier has not met the requirements of §133.304(p) or §133.307(e). Additionally, the Respondent has not demonstrated that it has provided any information or documentation to support its burden of proof to show that a specified amount of a refund was due from the health care provider. For these reasons, the respondent's request for an order of reimbursement is not proper and is not supported. An order of reimbursement for the respondent is therefore not recommended.

7. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The preauthorized length of stay is two days. The surgical per diem rate of $1,118 multiplied by the length of stay of two days results in an allowable amount of $2,236.00.
- 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
- A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $131,959.00.
- The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
Cancellous Chip 90cc	2	$1485.00	$1485.00 + $148.50 = $1633.50 X 2 = $3267.00
Grafton Gel	9	$1,150.00	$1,150.00 + $115.00 = $1265.00 X 9 = $11,385.00
Spinal Fusion Stimulator	1	No support for cost/ invoice	$0.00
Nut locking	7	$125.00	$125.00 + $12.50 = $137.50 X 7 = $962.50
Cancellous Chip 60xx	1	$990.00	$990.00 + $99.00 = $1089.00
BAK Interbody Cage	2	$2720.00	$2720.00 + $272.00 = $2992.00 X 2 = $5984.00
Implant Assembly	1	$245.00	$245.00 + $24.50 = $269.50
Trans Con Nut	6	$65.00	$65.00 + $6.50 = $71.50 X 6 = $429.00
Trans Con Insert	6	$95.00	$95.00 + $9.50 = $104.50 X 6 = $627.00

Transverse Connector	1	No support for cost/ invoice	$0.00
End Cap	2	$159.00	$159.00 + $15.90 = $174.90 X 2 = $349.80
Poly Screw	5	$875.00	$875.00 + $87.50 = $962.50 X 5 = $4812.50
TC, Fixed	2	$185.00	$185.00 + $18.50 = $203.50 X 2 = $407.00
Silhouet Rod	2	$290.00	$290.00 + $29.00 = $319.00 X 2 = $638.00
Rod Template	2	$115.00	$115.00 + $11.50 = $126.50 X 2 = $253.00
TOTAL DUE			$30,473.30

- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $289.00/unit for Dilaudid PCA 100ML and $425.00 for Morphine PCA. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The Division concludes that the total allowable for this admission is $32,703.90 ($2,236.00 + $30,473.30). The respondent issued payment in the amount of $35,859.80 for the surgical days. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually costly services, and failed to demonstrate that the services in dispute were unusually extensive. The requestor further failed to establish that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	6/27/2012 Date
Signature	Health Care Business Management Director	6/27/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

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